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Certificate of Need Assessment — Selected Information on Threshold and Moratorium Criteria

State of Washington

Final

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Contents

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Executive Summary

In this report, we examine the benefits and drawbacks of financial thresholds and the impact of moratoriums of Certificate-of-Need (CON) programs. This report is not intended to be an exhaustive review of the literature; time and resources permitting, additional detailed information could be extracted through a more extensive survey and interview process. The following is a summary of the benefits and drawbacks of thresholds, and our conclusions and points for the Task Force to consider.

Thresholds

Benefits and Drawbacks of CON Financial Review Thresholds

Benefits	Drawbacks
▪ Thresholds promote organizational planning by hospital groups and institutions.	▪ Certain threshold requirements may apply high administrative costs and burden state agencies.
▪ Thresholds allow state administrative agencies to control the diffusion and distribution of specific technology and services.	▪ National threshold criteria may not capture all cost drivers of rising healthcare costs.
▪ Thresholds provide the option of implementing CON in accordance with the goals of an overall state-health strategy.	▪ Thresholds are vulnerable to gaming.

Conclusions

From the selected literature and survey research that was conducted, the following conclusions can be made:

- little information is available in the literature that directly researches the area of threshold use and the benefits and drawbacks;
- not every state regularly makes updates to threshold values and criteria;
- minimal information regarding impacts from changes in threshold levels and review criteria are documented;

- in general, current threshold review criteria are not standard and do not promote data collection;
- opportunities for state administrative oversight and for data collection can be promoted through the use of financial threshold criteria;
- opportunities for facilitating State Plan goals can be advanced through the use of thresholds; and
- financial threshold gaming exists and is difficult to isolate or monitor.

Points to Consider

If financial threshold criteria for CON review are changed for Washington State, the Task Force should consider:

- the administrative burden of adding additional review criteria, etc should be assessed prior to implementation;
- including review criteria to include reporting of the existing equipment and services;
- establishing a schedule for threshold level and criteria review and potential updates;
- establishing benchmarks for and monitoring of the compliance and impact of the current and any other criteria change;
- monitoring project costs and key benchmarks and CON compliance requirements after CON approval has been awarded;
- considering tracking projects whose costs are above one half of the thresholds through a notice requirement;
- establish statutory language that would thwart "project splitting" to stay below the threshold levels and CON review criteria requirements, a la Vermont; and
- if a State Health Plan is to be developed, consider utilizing thresholds and review criteria to promote and motivate the goals of the Plan.

Moratoriums

Conclusions

Current assessments of the impacts or unintended consequences that have resulted from a moratorium on CON applications until a State Plan is implemented are very limited. While several states have recently implemented moratoriums for these purposes, the impacts are not widely available. The results from brief survey that we conducted also do not provide a significant amount of illumination on this issue.

From the selected literature and survey research that was conducted, the following conclusions can be made:

- CON moratoriums issued to limit the growth of utilization or cost savings are more prevalent than those issued in preparation of an overall CON program assessment or State Plan development;
- very little monitoring regarding the impact of CON moratoriums instituted in preparation for State Plan development has been conducted;
- for those state CON moratoriums for State Plan development that have monitored for specific elements, the resulting impacts are not yet available;
- most states that issued CON moratoriums included exceptions to the requirements; and

- during the period of time that a CON moratorium for State Plan development is in place, CON applications accumulate and seem to cause an increase in application submission when the moratorium is lifted.

Points to Consider

If a moratorium for Washington State CON is undertaken in anticipation of the development of a State Plan, the Task Force should consider:

- incorporating moratorium condition exceptions that reflect situations and services that, if they are continued, will not impact the overall intent of the central CON moratorium requirement or are required for maintaining necessary healthcare services to the citizens of the State, such as emergency needs, federal requirements, etc., to avoid an accretion of applications when the moratorium is lifted;
- including provisions to monitor the impacts of the moratorium; and
- maintaining as short a period of time necessary for the moratorium and devising an administrative contingency plan to efficiently manage an excess of CON application submissions that may result when the moratorium is lifted.

2

Introduction

Background

In this report, we examine the benefits and drawbacks of financial thresholds and the impact of moratoriums of Certificate-of-Need (CON) programs. Although many advocates and critics of CON programs emphasize cost containment as a goal of the program, CON was not initially developed as a tool solely for this purpose. Instead, as a result of insurance commissioner concerns over Blue Cross rate increases in the late 1950's, public health and private enterprise groups began working toward regional hospital planning.[1] During this same period, Medicare reimbursements rose to more than 80 percent of overall costs, influencing public policy and subsequent legislation.[2]

In 1964, New York State passed the Metcalf-McCloskey Act, which established the first state CON program[3] and legitimized it as a system to contain rising healthcare costs. Later, Section 1122 of the Social Security Amendments of 1972 established a national threshold for capital expenditure review. Set at $100,000, costs subject to review included capital costs, changes in services, and bed capacity adjustments. States choosing not to comply with this amendment were not eligible for federal Medicaid payments and Medicare capital reimbursement.[4] In 1974, Congress passed the National Health Planning and Resources Act (NHPRDA) which established thresholds for capital expenditures, major medical equipment and new services.[5] Within a few years twenty-four states had established CON laws that applied a wide range of financial thresholds.

Through other legislation during this period, CON regulatory policy, especially review thresholds, was structured to enable state administrative agencies to control duplication of services and excess competition. On the assumption that healthcare providers will promote the latest developments and technologies despite costs, 36 states currently administer CON programs.[6] Financial thresholds and moratoriums provide differing levels of control over CON programs.

Approach

Mercer Health and Benefits Consulting performed a selected literature review of over 20 reports, articles and books specifically related to review thresholds and moratoriums, historical and current use, in CON programs around the country. Mercer also conducted a short survey regarding review thresholds and moratoriums considered or implemented in five states that have recently evaluated their CON program and/or revised their programs.[7] In addition, as time allowed, Mercer also interviewed several CON officials in pertinent state administrative agencies that had recently undergone evaluation of, and amendments to, their CON programs. This report is not intended to be an exhaustive review of the literature; time and resources permitting, additional detailed information could be extracted through a more extensive survey and interview process.

Upon compiling relevant evidence of the effects of thresholds and moratoriums, Mercer structured this report to display the literature and survey results, followed by conclusions and a list of suggestions to consider. The remainder of this report is organized as follows:

- Section 2 — Threshold Criteria;
- Section 3 — Moratorium Criteria; and
- End Notes.

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Threshold Criteria

Issue for Study

Mercer's objective here was to determine the benefits and drawbacks to maintaining financial threshold criteria for CON, taking into consideration capital expenditures for a variety of items.

Literature Review Findings

Much of the current literature does not directly address the advantages and disadvantages of capital expenditure and equipment thresholds. Also there is little to no information regarding specific services and equipment threshold levels, and rationale for changes. However, we were able to extract information regarding the general benefits and drawbacks and the supporting rationale. Below, we present a table that briefly summarizes the benefits and drawbacks of CON financial review thresholds, followed by a more detailed review.

Benefits and Drawbacks of CON Financial Review Thresholds

Benefits	Drawbacks
▪ Thresholds promote organizational planning by hospital groups and institutions.	▪ Certain threshold requirements may apply high administrative costs and burden state agencies.
▪ Thresholds allow state administrative agencies to control the diffusion and distribution of specific technology and services.	▪ National threshold criteria may not capture all cost drivers of rising healthcare costs.
▪ Thresholds provide the option of implementing CON in accordance with the goals of an overall state-health strategy.	▪ Thresholds are vulnerable to gaming.

Benefits

Thresholds Promote Organizational Planning by Hospital Groups

In anticipation of regulation by state administrative agencies, hospitals and other groups applying for a CON not only display diligence in the application process, but are also shown to review and revise their short- and long-term plans in accordance with CON regulations.[8] Since states with stringent CON guidelines (usually those with lower threshold amounts) make it more difficult to obtain a CON, hospitals and groups are more likely to seriously plan and consider costs and benefits associated with an application.

Thresholds Control Distribution of Specific Services, Technology, and Equipment

CON financial thresholds allow state administrative agencies control over the distribution, availability, and concentration of equipment and new technology associated with state healthcare. Though actual innovation and new healthcare technology research cannot be stymied by state CON programs, differing degrees of regulation, mainly through financial thresholds, allow state administrative agencies to limit or expand allocation of technology and services within regional markets.[9] However, states are not completely invulnerable to rising expenditures stemming from new technologies. This phenomenon is supported by the fact that if new equipment or services fall below threshold dollar amounts, they are not subject to review (except where states initially review all new services/equipment regardless of financial threshold requirements).

Historical studies suggest that CON has not been effective in controlling the introduction or equitable distribution of overall technology throughout the healthcare market. Regarding distribution of high-capital technology, states have historically applied four distinct policy perspectives regarding threshold limits; these represent a range of financial threshold guidelines.[10]

- *A proforma denial* represents a very stringent policy on technology distribution by lowering thresholds while focusing attention on both capital and operating costs.
- *A formalized strategy of delay* is characterized by temporarily limiting rapid distribution of technology and services by implementing moratoria policy.
- *A predetermined limit on diffusion* caps annual expenditures by a predetermined dollar amount, resource, or utilization. This strategy is most prevalent in Maine's State Health Plan and their Capital Investment Fund (CIF).
- *Uncontested approval of all proposals* is a liberal implementation of financial thresholds. The goal of this plan is to maximize access and sometimes implement timely and adequate review of high-capital proposals by raising threshold dollar amounts.

Thresholds Provide the Option to Implement CON with a State Health Strategy

Although the passing of the National Health Planning and Resources Development Act provided funding incentives for states to align CON program goals with state health policy[11], the repeal of this act in 1979 provided the opening for states to implement a stand-alone CON program. Recently, after much criticism about failed cost savings measures, CON studies and regulators have presented that CON threshold criteria be implemented in conjunction with the priorities of an overall state health strategy. A 2004 report by the Consumers for Affordable Health Care Foundation (CAHC) supported that the Maine state health plan, Dirgio Health, serve as a guide to future CON decisions.[12] The same study also recommends that Maine consider decreasing its relatively high thresholds to comply with the goals of the Dirigo Health reforms. A 2001 study conducted by the Maine Department of Human Services also points out that a weakness of Maine's CON program, pre-Dirigo, is the lack of state-wide health planning and policy direction.[13]

Drawbacks

Thresholds May Apply High Administrative Costs

CON applications increase costs for both the applicants and state agencies required to implement the program. Controlling the different threshold levels also allows state agencies to directly affect application volume. While increasing a threshold, limiting review criteria, or minimizing data collection would potentially allow adequate reviews of CON applications, a lower threshold, increased review criteria and data submission requirements may burden an administrative agency with an increase in reviewable applications. Also CON application fees, which can cost up to $30,000 in Washington State[14], add to aggregate costs observed in the overall healthcare market.

Currently, a Duke University working paper by Christopher Conover and Emily Zeitler is examining the administrative costs to both administrative agencies and CON applicants. By researching the overall administrative cost that plays in the national CON scene, we may be able to analyze the true impact of these hidden costs.[15]

Current Threshold Review Requirements May Hinder Adequate Review and Capture of Cost Drivers

Under Washington State statute, the cost that is subject to financial thresholds is "not properly chargeable as an expense of operation or maintenance".[16] This definition forgoes any oversight of ongoing costs including operating and indirect costs associated with capital projects, equipment, and services. Ancillary costs may include maintenance, repairs, training, and support.[17] In this scenario, CON capture, restrain and monitor long-term healthcare expenditures associated with operating costs. To monitor these costs, and evaluate projects for in consideration of the annual Capital Investment Fund (CIF) limits, Maine guidelines mandate CON review for new third-year operating of $400,000 and greater.[18]

Including a review of existing equipment and services in the threshold review criteria is important to align CON policies with the review administration. For example, the initial intent of state-established CON policy was to contain costs by eliminating duplication of services and excess competition. However, CON guidelines differ widely and many states do not require review of existing equipment and services under the financial threshold review requirement. This permits equipment and services approvals that are not in alignment with state policies.

Services and technologies that fall below thresholds, and are not subject to review, may significantly contribute to rising healthcare expenditures over the long term. In the legislatively mandated, 2005 Commission to Study Maine Hospitals, it was reported that approximately 80 percent of capital investments in Maine fall below CON thresholds. To review the flow of these investments not captured by existing CON regulation, the Hospitals Study Commission recommended that hospitals and non-hospital providers be required to report to the CON unit those projects whose costs are above one-half of the current review thresholds.[19] Such reporting would provide information about the types of projects that are not currently reviewed, and assist in future planning. This recommendation was not implemented for the current Maine CON program.

Thresholds are Vulnerable to Gaming

We investigated the role of gaming and deceptive practices by healthcare industry applicants. A dearth of official literature is available that identifies specific gaming instances that have occurred. However, informal conversations and survey responses indicate an active level of gaming to circumvent CON regulations and financial thresholds, and have provided us with unofficial accounts of gaming activities.

Though identifying potential gaming opportunities may require deep industry knowledge, in order to combat gaming attempts, Vermont CON laws provide that "If the commissioner determines that a person required to obtain a certificate of need under this subchapter has separated a single project into components in order to avoid cost thresholds or other requirements under this subchapter, the person shall be required to submit an application for a certificate of need for the entire project…".[20]
More information on gaming is provided under a following section titled "Selected State Experience".

Selected State Experience

In order to better assess the effect of thresholds, we surveyed states that have recently considered amending CON guidelines and regulations. These states include Maine, Maryland, Kentucky, Connecticut, and Florida. Summarized responses from our survey are listed on the following page.

1. **During the program evaluation and CON law revisions in your state, did you consider dropping or eliminating monetary thresholds for CON assessment and just leaving the facility, capital investment or service type as the criteria? If yes, what was your outcome?**	
Maine	Maine did not consider eliminating thresholds.
Maryland	Responses not available as of 8/15/06
Kentucky	Kentucky indicated that most financial review expenditure thresholds were eliminated more than 15 years ago. However, Kentucky does enforce a $2,177,866 capital expenditure threshold for those projects, equipment, and other expenditures that are not directly regulated by the State Health Plan.
Connecticut	Connecticut indicated that it did not consider eliminating thresholds.
Florida	Although Florida eliminated capital expenditure and equipment thresholds in 1997, no response was given for the rationale behind the move. No follow-up study has been done to measure the effect of eliminating financial thresholds in Florida.

2. **During the program evaluation and CON law revisions in your state, did you consider changing the threshold amounts overall or for individual facility, capital investment or service type? If yes, how did you change thresholds for individual services? What were your guidelines for change?**	
Maine	Yes. At the time of the CON program revision, Maine threshold review amounts were higher than the majority of comparable states, thus fewer projects were subject to review. Although some signs pointed to lowering threshold amounts, Maine did not change thresholds, citing a need for more analysis. An increase for inflation was agreed upon and is imposed annually to each of the threshold levels.
Maryland	Responses not available as of 8/15/06.
Kentucky	Most projects, equipment, and services that are commonly regulated by financial thresholds are actually outlined for review and governed by the State Health Plan.
Connecticut	There had been support to increase the threshold since its last revision in 1987. In adjusting financial thresholds, Connecticut took note that several surrounding states set capital expenditure thresholds at $5 million. However, the Legislature set threshold levels to $3 million for capital expenditures. The threshold for some medical equipment is also set at $3 million, while equipment utilizing new technologies is subject to review regardless of cost.
Florida	Florida does not enforce financial thresholds for CON review.

3. **How often do you evaluate and/or change threshold levels?**	
Maine	Threshold levels are updated annually.
Maryland	Responses not available as of 8/15/06.
Kentucky	Threshold levels are updated annually.
Connecticut	Did not indicate frequency for review.
Florida	Florida does not enforce financial thresholds for CON review.

4. **Do you find that gaming currently takes place to "get under" the threshold levels?**	
Maine	Maine indicated that they are aware of gaming activities that takes place regarding CON reviewability and thresholds and Capital Investment Fund (CIF) levels.
Maryland	Responses not available as of 8/15/06.
Kentucky	Kentucky was not aware of any gaming stemming from the levels of criteria.
Connecticut	Connecticut indicated that there has always been a certain level of gaming that occurs in the state.
Florida	Florida does not enforce financial thresholds for CON review.

Additional Threshold Information for Comparable States

Maine

- As a part of Dirigo Health, Maine's largest State Health Plan, financial threshold triggers are currently: $2.4 million for capital expenditures, $1.2 million for major medical equipment, and $110,000 for expenditures for services or $400,000 for third-year operating expenses.
- Under the state plan, a CIF was established in order to provide an annual limit on the dollar amount of expenditures approved under the CON program.
- In 2005, the Hospital Study Commission considered recommending a lower financial review threshold in order to capture approximately 80 percent of capital outlays that fell under the thresholds at the time. Without further data to support this, the Hospital Study Commission recommended that hospitals and non-hospitals be required to report projects where costs exceed one-half of current review thresholds.
- Under the theory that regulation of the healthcare market through CON has the potential to keep costs lower or to moderate the rate of increases on behalf of consumer, business and government payers, and noting that Maine's review thresholds were higher than those in the vast majority of other states that establish thresholds for CON review, the Maine consumers coalition, Consumers for Affordable Health Care (CAHC), recommended that review thresholds be lowered. They indicated that the lower thresholds were justified given the size of Maine's population, the distribution of the population, the heavy consolidation of Maine's healthcare delivery system, the competitive advantages that the state's largest insurer has developed, Maine's geography and topography, and the low household income levels relative to other states. CAHC presented that each of these characteristics has

impaired the development of any significant cost competition in Maine.

Maryland

- In 2005, the capital expenditure threshold triggering CON review was $1.65 million.
- Hospitals and other groups that pledge not to seek increases in patient charges or hospital rates of more than $1,500,000 for scheduled costs are not subject to CON review.
- At the end of 2005, a commission recommended that the thresholds be increased to $10 million for hospitals regulated by the HSCRC and $5 million for all other facilities.
- The commission also recommended the elimination of duplicative CON regulation found within the existing State Health Plan and CON statutes.

Michigan

- The capital expenditure threshold triggering CON review is currently $2,715,000 for construction and renovation projects.
- Health facilities, physicians, and physician groups, among other groups, must apply for a CON for certain projects regardless of the expenditure amount.
- Michigan does not implement a standard threshold amount for all major medical equipment. Instead, only certain types of equipment are subject to review.
- CON guidelines indicate that an applicant must demonstrate that the capital costs will lead to the lowest annual operating costs.
- A study from 2002 indicated that Michigan "maintains a relatively more stringent CON program than do surrounding states, based on current review thresholds for capital and equipment…compared to all states, Michigan is in the middle tier of states in terms of stringency…relatively lenient thresholds for capital expenses is offset by its fare more stringent standard for review of major medical equipment…"

Florida

- Projects in Florida are not reviewable when based solely on capital expenditure thresholds.
- Since 1997, purchase or transfer of medical equipment has not been subject to review despite cost.
- Although cost overruns were subject to review, since 2000, project cost overruns have been exempt from any CON oversight.
- Projects subject to review include, and are not limited to, an increase in licensed bed capacity, conversion of types of healthcare facilities, new construction or an addition to existing facilities, and an addition of beds.

Kentucky

- The goals of the CON program are aligned with the Kentucky state-health plan.
- Those projects and services not reviewable under the State Health Plan are subject to a $2,177,866 capital expenditure threshold.
- CON review requirements, in compliance with the State Health Plan, also examine need requirements, such as demographics, local markets, and financial feasibility of the project.

Conclusions and Points for Consideration

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From the selected literature and survey research that was conducted, the following conclusions can be made:

- little information is available in the literature that directly researches the area of threshold use and the benefits and drawbacks;
- not every state regularly makes updates to threshold values and criteria;
- minimal information regarding impacts from changes in threshold levels and review criteria are documented;
- in general, current threshold review criteria are not standard and do not promote data collection;
- opportunities for state administrative oversight and for data collection can be promoted through the use of financial threshold criteria;
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- financial threshold gaming exists and is difficult to isolate or monitor.

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If financial threshold criteria for CON review are changed for Washington State, the Task Force should consider:

- the administrative burden of adding additional review criteria, etc should be assessed prior to implementation;
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- establishing benchmarks for and monitoring of the compliance and impact of the current and any other criteria change;
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- considering tracking projects whose costs are above one half of the thresholds through a notice requirement;
- establish statutory language that would thwart “project splitting” to stay below the threshold levels and CON review criteria requirments, a la Vermont; and
- if a State Health Plan is to be developed, consider utilizing thresholds and review criteria to promote and motivate the goals of the Plan.

4

Moratorium Criteria

Issue for Study

Our objective here was to determine the impacts or unintended consequences resulting from a moratorium on CON applications appending implementation of a State Plan. Due to the narrow subject, we cast our search widely and reviewed the impacts of a broad range of CON moratoriums. The findings and conclusions are limited for our specific purpose, but are outlined below.

Literature Review Findings

Many states have imposed various types of CON-related moratoriums over the past several decades. Generally there are two reasons for imposing the moratoriums: to limit the growth of utilization, thus promote cost savings, or to prepare for an overall CON program assessment or state plan development. Impacts resulting from moratoriums that sought to produce cost savings have been well studied and the outcomes defined, while those that were constructed to allow time for program assessment or state plan development have not been studied and documented as well. This applies to both the types of moratoria.

Impacts of Moratoriums to Limit Utilization or Cost Savings

The majority of moratoriums to limit growth of utilization or cost savings have been focused on nursing homes through the use of construction moratoria. In 2002, 17 states had a construction moratorium in place, compared to 18 states in 1998.[21] Impact findings from these types of moratoriums are somewhat mixed.

- A study of state construction moratoria on nursing bed growth between 1979 and 1993 found that the presence of either CON or moratorium requirements resulted in a statistically significant reduction of bed growth.[22]

- A review of state CON or moratoriums on nursing homes and the resulting impact on Medicaid spending for home and community-based services (HCBS) between 1990 and 1997 found that either CON or a moratorium constrained institutional spending and redirected Medicaid dollars to HCBS.

- A study of states that repealed their CON and moratoriums indicated no long term effect on Medicaid expenditures.[23]

A key feature all of the states' cost savings moratorium language included exception policies. Grabowski's 2004 study contacted each of the states with nursing home moratoria to determine the exceptions. Most states provided an exception for any expansions "required" by federal law, or necessary to meet a critical public health need, and some allowed for modest expansions in small nursing homes. These exceptions explained the bed growth experienced by some of those states with bed construction moratorium.

Impacts of Moratoriums for Program Assessment or State Planning

Impacts resulting from moratoriums issued to allow for program assessment or state planning have generated very little information in the literature. The most available information is from the state of Maine, where it was reported that in the eight weeks following the expiration of the CON moratorium, $214 million in new capital spending were proposed through Letters of Intent in May 2004. This was an increase over the annual average $65 million approved for CON projects between 2001 and 2003.[24] However, conversations with the Governor's Office of Heath Policy and Finance (GOHPF) revealed that the approval for the projects referenced in the May 2004 Letters of Intent was actually less than the reported $214 million.[25] The CIF that was established under the Maine State Plan also contributed to limiting the overall amount approved in 2005.

While more information is provided under the Selected State Experience section below, a key feature of the state CON moratorium orders are the exceptions to services and facilities requirements. The one-year moratorium on the Maine CON program was implemented with exceptions for approvals already made, requests already received and emergencies.[26] These applications were submitted and processed as usual.

Kentucky has also had a series of moratoriums, which were extended and recently expired in December 2005. Their second set of moratoria since 2000 were established January 2003 through January 2004 and did not affect pending applications; those applications where there was "good cause shown that an emergency exists and upon recommendation from the governor that an emergency exists"; or applications that involved "relocation of a facility within the same county or replacement of a facility which fails to meet life safety codes, with approval limited to the facility's current complement of licensed beds."[27]

Subsequent extensions to the Kentucky moratoriums, issued in July 2005, continued these exemptions as well as those made earlier to exempt applications to establish MRI services at hospitals or hospital-owned healthcare facilities licensed as ambulatory care clinics or specialized medical technology clinics. The extension also continued to exempt applications to respond to an emergency and that result from changes to state law or court orders, and added an exception for those applications not requiring substantive review. It was noted that there were over 80 applications awaiting review since the previous moratorium was issued. The substantive review exception was projected to ease this backlog.[28]

Selected State Experience

In order to better determine the impacts that have resulted from current state CON moratoriums, we surveyed states that have recently considered amending, or have amended, CON guidelines and regulations. These states include Maine, Maryland, Kentucky, Connecticut, and Florida. The summarized responses from our survey our listed below.

1. **During the program evaluation and CON law revisions in your state, did you place a moratorium on applications submittal and approvals of CON applications and projects? If yes, what were the circumstances and what was the impact?**	
Maine	"A moratorium was placed on all CON reviewable projects from May 03 – June 04 in order that the State could have time to move ahead with creating the State Health Plan. This allowed an application-free period to avoid variable evaluation guidelines when the new State Plan took effect. Impact was tracked by the letters of intent and overall amounts approved, however no conclusions attributable to the impact of the moratorium could be determined to date." Maine also indicated that the Capital Investment Fund (CIF) must also be considered as an impact in this measure.
Maryland	Responses not available as of 8/15/06.
Kentucky	Kentucky indicated that though moratoriums have previously been placed on CON applications, no follow-up studies were undertaken to examine the effects of the moratorium.
Connecticut	Connecticut indicated that no official moratorium was implemented.
Florida	In 2001, Florida placed a moratorium on community nursing home beds. No moratorium on hospital CON applications was indicated.

2. **During the program evaluation and CON law revisions in your state, did you place a moratorium on applications submittal and approvals of CON applications and projects? If yes, what were the circumstances and what was the impact?**	
Maine	"A moratorium was placed on all CON reviewable projects from May 03 – June 04 in order that the State could have time to move ahead with creating the State Health Plan. Impact was tracked by the Letters of Intent that were received for approval in 2005. There was an increase in the Letters of Intent received for approval for 2002 – 2004, but the number was similar to the number filed in 2001, thus no conclusions attributable to the impact of the moratorium could be determined." Maine also indicated that the Capital Investment Fund (CIF) must also be considered as an impact in this measure.
Maryland	Responses not available as of 8/15/06.
Kentucky	Kentucky indicated that though moratoriums have previously been placed on CON applications, they could not recall the reasoning or any follow-up studies undertaken to examine the effects of the moratorium.
Connecticut	Connecticut indicated that no official moratorium was implemented.
Florida	"In 2001, the Florida legislature placed a moratorium on the issuance of certificates of need for additional community nursing home beds until July 1, 2006. In 2006, the legislature extended the moratorium until July 1, 2011. This action was taken because the legislature found that the continued growth in the Medicaid budget for nursing home care constrained the ability of the state to meet the needs of its elderly residents through the use of less restrictive and less institutional methods of long-term care. After the first five-year moratorium there was only slight increase in utilization in skilled nursing beds statewide. There are exceptions to the moratorium."

Conclusions and Points for Consideration

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From the selected literature and survey research that was conducted, the following conclusions can be made:

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Points for Consideration

If a moratorium for Washington State CON is undertaken in anticipation of the development of a State Plan, the Task Force should consider:

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- including provisions to monitor the impacts of the moratorium; and
- maintaining as short a period of time necessary for the moratorium and devising an administrative contingency plan to efficiently manage an excess of CON application submissions that may result when the moratorium is lifted.

Endnotes

[1] Sallyanne Payton; Rhoda M., *Regulation through the Looking Glass: Hospitals, Blue Cross, and Certificate-of-Need,* Powsner Michigan Law Review © 1980 The Michigan Law Review Association http://proxy.library.upenn.edu:8117/journals/mlra.html.
[2] *Interim Report of the Florida Certificate of Need Workgroup*; CON Workgroup, State of Florida, December 31, 2001.
[3] Metcalf-McCloskey Act of 1964, ch. 730, [1964] N.Y.Laws 1883.
[4] Pub. L. No. 92-603, 86 Stat. 1329 (1972) (codified as amended at 42 U.S.C. § 1320a-1 (1976 & Supp. V 1981)).
[5] Pub. L. No. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. § 300k–300n-6 (1982)), *amended by* Health Planning and Resources Development Amendments of 1979, Pub. L. No. 96-79, §§ 1–129, 93 Stat. 592 (codified at 42 U.S.C. §§ 300k–300t (1976 & Supp. V 1981), *repealed by* Pub. L. No. 99-660, § 701, 100 Stat. 3743, 3799 (1986).
[6] National Director of Health Planning, Policy, and Regulatory Agencies, (American Health Planning Association 15th d. 2005). Available at http://www.ahpanet.org/images/ahpadirectoryinfo.pdf.
[7] Michigan was included in the original five states selected for interview; however their CON administrative agency is currently undergoing restructure. Therefore, Michigan declined to participate in the survey. Kentucky was substituted for their recent use of moratoriums in their CON program.
[8] Frank A. Sloan, Bruce Steinwald, *Effects of Regulation on Hospital Costs and Input Use*, April 1980 Journal of Law and Economics, pg. 84-85.
[9] Alan B. Cohen, Donald R. Cohodes, *Certificate of Need and Low Capital-Cost Medical Technology*, Spring 1982 The Milbank Memorial Fund Quarterly. Health and Society, pg. 312-314.
[10] *Ibid*., pg. 314-319.
[11] Pub. L. No 93-641, 88 Stat. 2225 (1975) (42 U.S.C. § 300k-300n-6 (1982)) *repealed by* Pub. L. No. 99-660, § 701, 100 Stat. 3743, 3799 (1986).
[12] Hilary K. Schneider, Joseph P. Ditré, *When, Where and How Much: Improving Maine's Certificate of Need Program*, Consumers for Affordable Health Care Foundation, June 2004, pg. 2, 12-13, 15.
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